Grace Perio and Implants

info@graceperio.com www.graceperio.com

13810 John Audubon Pkwy, # C • Webster, TX 77598 (281)286-0056

Patient Information

Patient Name: _____ * _____ * _____ _____
Last First MI Preferred Name

Address: _____ * _____
Address 1 Address 2

_____ * _____ * _____-_____ *
City State Zip Code

Phone: _____ * _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Date of Birth * _____

Email Address *

_____

_____

Pharmacy and Phone Number *

_____

_____

Height/Weight * _____

Your General Dentist is:

_____

_____

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering ALL of the following questions.

Have there been any changes in your general health within the past year? Please list ALL including hospitalization and diagnosis

_____

Date of your last physical exam _____

Provide the office with the following information: Physicians Name/Specialty, Group Name, City and phone numbers *

_____

_____

LIST ALL MEDICATIONS: INCLUDING Prescription, non-prescription and over the counter medication. Please include: name, strength, frequency and reason for taking *

_____

_____

_____

_____

_____

Are you currently or have you ever taken a drug or IV infusion for osteopenia or osteoporosis, commonly known as Bisphosphonates? (eg. Fosamax, Actonel, Didronel, Boniva, Aclasta, Loron, Zometa, etc.) *

◯ Yes ◯ No

If so, which one and how long? *

_____

_____

Do you or have you used controlled substances? ◯ Yes ◯ No

Do you currently smoke tobacco OR use a Vape to smoke? *

◯ Smoke Tobacco ◯ Vape ◯ None

Are you currently on Semaglutide or similar medications as Ozempic or Monjauro? * ◯ Yes ◯ No

Do you have any disease,conditon or problem not listed above that you think I should know about ◯ Yes ◯ No

Do you have or have you ever had any of the following medical issues?

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer (Previous or Current)
- ☐ Cardiac Implanted Devices (Not Pacemakers)
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Cholesterol
- ☐ Cold sores/fever blisters
- ☐ Cough that produces blood
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Fainting/Dizzy spells
- ☐ Glaucoma
- ☐ Heart problems
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

- ☐ Hives/skin rash
- ☐ Hyperglycemic
- ☐ Hypoglycemia
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hip replacement
- ☐ Joint replacement
- ☐ Kidney problems
- ☐ Mental health care
- ☐ Pacemaker

- ☐ Require pre-med
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING: *

- ☐ Local anesthetic (like novocaine)
- ☐ Antibiotics
- ☐ Latex/Rubber
- ☐ Any metals (nickel, mercury, etc)
- ☐ Other: USE NEXT BOX TO ADD ANY ALLERGIC ISSUES NOT LISTED ABOVE
- ☐ No Known Drug Allergies

List ALL Allergies NOT listed above: *

_____

_____

_____

Women Only

Do any of the following apply to you:

- ☐ Pregnant or think you may be pregnant
- ☐ Nursing
- ☐ Taking birth control pills
- ☐ Breast implants

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand that full payment is due at the appointment time for all types of exams, x-rays and cleanings. For surgical treatment, financial arrangements will be discussed after verification of insurance coverage. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. SEE HIPPA I give my consent to any advisable and necessary procedures, medications or anesthetics to be administered by the attending Dentist/Periodontist or staff for diagnostic or treatment purposes. I will not hold Dr. Crofcheck or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. We reserve the right to charge interest on any unpaid balances. All accounts past 90 days will be sent to the collection agency and additional processing fees will be incurred.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____